

Title: Gender Dysphoria Services for CHP and Commercial LOBs	Division: Medical Management Department: Utilization Management
Approval Date: 8/9/17	LOB: CHP, QHP, Essential, MetroPlus Gold, MetroPlus Goldcare
Effective Date: 8/9/17	Policy Number: UM-MP208a
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1. POLICY DESCRIPTION:

Gender Reassignment Surgery

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claims Department, Provider Contracting.

3. DEFINITIONS:

Gender identity	The sense of being male or female that is usually in accord with, but sometimes opposed to, physical anatomy.
Gender dysphoria	Refers to discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a sex.
Transgender	Refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their gender at birth.
Transsexual	Refers to an individual who seeks, or has undergone, a social transition from male to female or female to male. In many, but not all, cases this also involves a physical transition through cross-sex hormone treatment and surgery (including sex reassignment surgery).
Hormonal gender reassignment	The administration of androgens to genotypic and phenotypic females and estrogen or progesterone to genotypic or phenotypic males for the purpose of effecting somatic changes to more closely approximate the physical appearance of the genotypically other sex. Hormones are also utilized for pubertal suppression. Hormonal gender reassignment does not refer to the administration of hormones for the purpose of medical care or research conducted for the treatment or study of non-gender-dysphoric medical conditions (e.g., aplastic anemia, impotence, cancer).

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Genital surgical gender reassignment	Genital surgery that alters the morphology to approximate the physical appearance of the genetically other sex. The surgical procedures on the table in Section 6 below occurring in the absence of any diagnosable birth defect or other medically defined pathology (except gender dysphoria) are included in this category.	

4. POLICY:

A. Pharmacological Treatment

- i. Hormone therapy (whether or not in preparation for gender reassignment surgery) will be covered for members ≥ 18 years of age as follows:
 - a. Treatment with gonadotropin-releasing hormone agents (for pubertal or menstrual suppression) when based upon a determination by a qualified medical professional that the member is eligible and ready for such treatment, i.e., that the member:
 - I. Meets gender dysphoria diagnostic criteria;
 - II. Has experienced puberty to at least Tanner stage 2 with pubertal changes resulting in increased gender dysphoria;
 - III. Does not suffer from mental health comorbidity that interferes with diagnostic work-up or treatment;
 - IV. Has adequate psychological and social support during treatment;
 - V. Demonstrates knowledge and understanding of expected treatment outcomes associated with drug therapies as well as the medical and social risks and benefits of sex reassignment, when applicable
 - VI. Medication is prescribed by or in consultation with a provider who specializes in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) and has collaborated with a mental health provider for members less than 18 years of age.
 - b. Treatment with cross-sex hormones for members ≥ 16 years of age is covered when based upon a determination by a multidisciplinary team of medical professionals that the member is eligible and ready

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for such treatment as outlined above. Requests for coverage of cross-sex hormones for members <16 years of age who meet the above criteria, will be reviewed on a case-by-case basis.

- ii. Progestins (for pubertal or menstrual suppression) covered without review and/or limitations.
- iii. Contraception is covered without review and/or limitations.
- iv. Lab monitoring is covered without review and/or limitations.

B. Gender Affirming Surgery

- i. Gender affirming surgery will be covered for members ≥ 18 years of age. Requests must be accompanied by a letter from a qualified New York State (NYS) licensed health professional, acting within the scope of his/her practice, who has independently assessed the member and is referring the member for the surgery. The request must establish:
 - a. Has a persistent and well-documented case of gender dysphoria;
 - b. Has received hormone therapy (not prerequisite for mastectomy) appropriate to member's gender goals for a minimum of 6 months prior to seeking genital surgery (unless medically contraindicated or the member is otherwise unable to take hormones);
 - c. Has lived at least 6 months in gender role congruent with member's gender identity and has received mental health counseling as deemed medically necessary during that time
 - d. Has no other significant medical or mental health conditions that would be a contraindication to gender reassignment surgery, or if so, that those are reasonably well-controlled prior to the gender reassignment surgery;
 - e. Has the capacity to make fully informed decisions and consent to treatment.
- ii. For requests that meet above criteria (B.i.), MetroPlus covers the following procedures, most of which are included in 18 NYCRR 505.2(l), paragraph 4: reduction mammoplasty (including breast liposuction), mastectomy, hysterectomy, salpingectomy, oophorectomy, vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, penectomy, vulvoplasty,

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orchiectomy, vaginoplasty, labiaplasty, clitoroplasty, placement of a testicular prosthesis, penile prosthesis, breast augmentation¹, electrolysis (required for vaginoplasty or phalloplasty), tattooing of the nipple-areola, chondrolaryngoplasty and vocal cord surgery.

- iii. All other surgery and procedures not included in the above list (based on 18 NYCRR 505.2(l) paragraph 4) may be considered cosmetic and not medically necessary when performed as part of surgical treatment for gender dysphoria. These requests will be reviewed on a case-by-case basis. The request and supporting documentation must establish that the surgery or procedure is required to treat the patient's gender dysphoria, as documented by a medical professional, and not to simply improve the patient's appearance. Requests must establish:
 - a. Gender dysphoria is marked and sustained even after hormone treatment and/or procedures listed in Section B.i. above.
 - b. That the body part(s), and procedure(s) requested are the sole cause of the patient's persistent gender dysphoria, and that the procedure is likely to eliminate or substantially reduce the patient's dysphoria.

C. Gender Affirming Surgery for Patients Under Age 18

Although coverage of gender reassignment surgery is generally for individuals 18 years of age or older, surgery for individuals under 18 will be covered in specific cases if medical necessity is demonstrated and prior approval is received.

- i. Mental Health Services needed to diagnose Gender Dysphoria and guide treatment, including gender reassignment surgery, are covered and not subject to prior authorization. These include inpatient and outpatient services and comprehensive assessments. Providers that are competent or specialized in treating gender diverse individuals are available in our network.
- ii. Routine Primary care, gynecological care and behavioral health care for gender diverse individuals are all covered and not subject to review or prior

¹ Breast reconstruction (augmentation), implant and/or tissue extender, provided that: the patient has completed at least 6 months of hormone therapy, during which time breast growth has been negligible; or hormone therapy is medically contraindicated; or the patient is otherwise unable to take hormones.

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authorization.

- D.** Requests for gender reassignment surgery and procedures for members < 18 years will require input from a multidisciplinary team of mental health and medical professionals who have an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender-related surgery until the transition is made to adult care.

E. Limitations/ Exclusions:

Only the following services will be denied based on noncoverage:

- For CHP only, cryopreservation, storage, thawing of reproductive tissue, and all related services;
- Reversal of genital and/or breast surgery;
- Reversal of surgery to revise secondary sex characteristics;
- Reversal of any procedure resulting in sterilization.

5. APPLICABLE PROCEDURE CODES:

CPT	Description
19303 Y	Mastectomy, simple, complete
19318	Reduction mammoplasty (unilateral)
19325	Breast augmentation with implant
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra.
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra.
53430	Arthroplasty, reconstruction of female urethra
54120	Amputation of penis: partial
54125	Amputation of penis; complete

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54520Y	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54522	Orchiectomy, partial
54660	Insertion of testicular prosthesis (separate procedure)
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55150	Resection of scrotum
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55899	Insertion of testicular prosthesis (separate procedure)
55980	Scrotoplasty; complicated
56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57106	Vaginectomy, partial removal of vaginal wall
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57110	Vaginectomy, complete removal of vaginal wall
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach

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57335	Vaginoplasty for intersex state
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach
57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250g; with repair of enterocele
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g

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58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral

6. APPLICABLE DIAGNOSIS CODES:

CODE	Description
F64.0	Transsexualism
F64.1	Dual role transvestism
F64.8	Other gender identity disorders (Effective 07/01/2017)
F64.9	Gender identity disorder, unspecified (Effective 07/01/2017)

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Z87.890 Personal history of sex reassignment

7. REFERENCES:

- i. 18 CRR-NY Title 505.2 (l) Gender dysphoria treatment
<https://regs.health.ny.gov/volume-c-title-18/content/section-5052-physicians-services>
- ii. NYS Physician-Surgery Provider Manual
<https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Sect5.pdf>
- iii. Sterilization Consent Form
https://www.health.ny.gov/health_care/medicaid/publications/docs/ldss/ldss-3134.pdf
- iv. New York State Department of Financial Services. IVF and Fertility Preservation Law Q&A Guidance. (Part L of Chapter 57 of the Laws of 2019)
https://www.dfs.ny.gov/apps_and_licensing/health_insurers/ivf_fertility_preservation_law_qa_guidance. Accessed November 5th, 2020.
- v. New York State Office of Mental Health Update-May 14, 2024. Clinical Review Criteria for the Treatment of Gender Dysphoria: New Standards of Care for the Transgender Health. Chapter 57 of the Laws 2019 added a new provision to the utilization review program standards in Insurance Law 4902 and Public Health Law 4902.
- vi. Coleman E, et.al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int J Transgender Health. 2022 Sep 6;23(Suppl 1):S1-S259. doi: 10.1080/26895269.2022.2100644. PMID: 36238954; PMCID: PMC9553112.

8. REVISION LOG:

REVISIONS	DATE
Creation date	3/27/2026
Updated	8/3/2026

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Approved:
Date:
Approved:

Sanjiv Shah
MD

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Date:

Sanjiv Shah, MD
Chief Medical Officer

Medical Guideline Disclaimer:

Property of MetroPlus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, MetroPlus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria. Based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at the time of publication. MetroPlus Health Plan has adopted the here-in policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.